

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00736					00736						
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Grant						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY in 1b 4 days 18 Hrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gormaniam 85.3						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett County Memorial Hospital					d. STREET ADDRESS P.O. Box #96			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Evers Middle Orloff Last BOSLEY					4. DATE OF DEATH Month January Day 26 Year 1967						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1895		9. AGE (in years last birthday) 71 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Mail Carrier			10b. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (County & State, or foreign country) Gormaniam, W. Va.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Newton George Bosley					14. MOTHER'S MAIDEN NAME Mary V. Boseley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW I 235-32-6659		17. INFORMANT (Wife) Estella Otilia Bosley,			Address Box #96 Gormaniam, W. Va.			
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Lung (c) same PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH same			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1950 , to 26 Jan 67 , that (I) (we) last saw the deceased alive on January 26 1967 , and that death occurred at 7:18 AM from the causes and on the date stated above.											
22a. SIGNATURE Andrew E. Mance					22b. DATE SIGNED 26 Jan 67			22c. PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1/28/67		23c. NAME OF CEMETERY OR CREMATORY Pope Cemetery		23d. LOCATION (City, town or county) (State) Gormaniam, W. Va.		
24. FUNERAL DIRECTOR John O. Durst					25a. REC'D BY REGISTRAR JAN 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			DATE	

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

00737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00737

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u> <u>11/1</u>	
c. LENGTH OF STAY IN lb <u>30 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 "G" Street</u>		d. STREET ADDRESS <u>104 "G" Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>LAWRENCE</u> Last <u>CURRAN</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4th.</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1900</u>
9. AGE (In years lost birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilkinsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Curran</u>		14. MOTHER'S MAIDEN NAME <u>Catherine M. Kanary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-32-1112</u>	
17. INFORMANT <u>Thomas Curran, Monroeville, Pa.</u>		Address (Son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerosis, generalized,</u> DUE TO (c) <u>Bronchial asthma. Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchial asthma. Chronic myocarditis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>3</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr., M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>1-5-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Oakland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John O. Durst</u>		25a. REC'D BY REGISTRAR <u>John O. Durst</u>	
25b. REGISTRAR'S SIGNATURE <u>John O. Durst</u>		DATE <u>JAN 9 1967</u>	

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STANDARD FORM NO. 64

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CERTIFICATE OF DEATH

Reg. Dist. No.

00738

00738

1. PLACE OF DEATH a. COUNTY <u>CARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11.1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELLA</u> <u>MARIE</u> <u>FAZENBAKER</u>				4. DATE OF DEATH Month Day Year <u>JAN</u> <u>12</u> <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1888</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GRANTSVILLE GARRETT MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY DORST</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA HARE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIABETES MELLITUS</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ADVANCED ARTERIOSCLEROSIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>58</u> , to <u>JAN</u> , 19 <u>67</u> that I last saw the deceased alive on <u>NOV 6</u> , 19 <u>66</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>226 E. ALDEN ST</u> DATE SIGNED <u>1/14/67</u>			
PHYSICIAN'S NAME (Type) <u>E. BAUMGARDNER</u>				OAKLAND MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/15/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHESDA</u>	
22d. LOCATION (City, town, or county) (State) <u>CARRETT Co MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 25 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00739					00739					
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND, MD					c. LENGTH OF STAY IN 1b 15 mo					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) COPPETT-WEEKS NURSING HOME					e. STREET ADDRESS RURAL GRANTSVILLE, MD 11.1					
3. NAME OF DECEASED (Type or print) First Middle Last LEBBIUS THADDA FAZENBAKER					4. DATE OF DEATH Month Day Year JAN 22 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1879 JAN. 22 1889		9. AGE (in years last birthday) 88		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER					10b. KIND OF BUSINESS OR INDUSTRY COAL MINES		11. BIRTHPLACE (County & State, or foreign country) GARRETT CO. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES FAZENBAKER					14. MOTHER'S MAIION NAME HESTER SEIBERT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eliza Matheny, Friendsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 DUE TO GANGLIOME RT FOOT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED GENERALIZED ARTERIOCLEROSIS (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 6 months ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAR 3 1965, to JAN. 22 1967, that (I) (we) last saw the deceased alive on JAN 22 1967, and that death occurred at 6:00 AM, from the causes and on the date stated above.										
22a. SIGNATURE E.J. Baumgardner					22b. DATE SIGNED 1/25/67		22c. PHYSICIAN'S NAME (Type) E.J. BAUMGARDNER			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 1/25/67		23c. NAME OF CEMETERY OR CREMATORY ADDISON			
24. FUNERAL DIRECTOR Don Newman, Grantsville, Md.					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			

James Hester
1/24/87
Hester, James H.

James Hester, 1/24/87

James Hester
Car. Hester
Hester, James H.
Hester, James H.

James Hester
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James Hester
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Hester, James H.

00740

CERTIFICATE OF DEATH

00740

1. PLACE OF DEATH a. COUNTY <u>Carrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Grant</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carroll</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Gormanian</u>		85.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Rest Nursing Home</u>		d. STREET ADDRESS <u>Route #1, Box #203</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>DESOTO</u> Last <u>FOLEY</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1879</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Soft Coal</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Grant Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas W. S. Foley</u>		14. MOTHER'S MAIDEN NAME <u>Mary High</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>419-03-8182</u>	
17. INFORMANT <u>Lester Foley, Gormanian, W. Va.</u>		Address (Son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Arteriosclerotic C.V.D.</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , to <u>Jan 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A. E. Mance</u>		22b. DATE SIGNED <u>1/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. E. Mance, M.D.</u>		22d. ADDRESS <u>Oakland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bayard Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bayard, W. Va.</u>
24. FUNERAL DIRECTOR <u>John O. Durst</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 30 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02704

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00741					00741				
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Deer Park</u> c. LENGTH OF STAY IN 1b <u>5 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 2</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deer Park</u> d. STREET ADDRESS <u>Rt. 2</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Sarah</u> <u>Sobina</u> <u>Foster</u> First Middle Last					4. DATE OF DEATH <u>Jan. 8,</u> <u>1967</u> Month Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1881</u>		9. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Deer Park, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry Jordan</u>					14. MOTHER'S MAIDEN NAME <u>Justina Kope</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>217-54-6204</u>		17. INFORMANT <u>Mrs. Daisy Schmidt</u> Address <u>Deer Park Rt. 2, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ADVANCED A-B-C-V-DISEASE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> <u>1957</u> to <u>JANUARY</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>JAN. 7</u> <u>1967</u> , and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <u>E. J. Baumgartner</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/9/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. J. BAUMGARTNER</u> M.D.					22d. ADDRESS <u>226 E. ARDEN ST. OAKLAND MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>			23d. LOCATION (City, town or county) <u>Oakland, Md/</u> (State) _____		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald H. Minnich</u> ADDRESS <u>Oakland, Maryland</u>					25e. REC'D BY REGISTRAR <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TESTIMONY OF DEATH

00011

00011

2. Age

2. Age

3. Sex

3. Sex

4. Date of Birth

4. Date of Birth

5. Place of Birth

5. Place of Birth

6. Date of Death

6. Date of Death

7. Cause of Death

7. Cause of Death

8. Time of Death

8. Time of Death

9. Name of Physician

9. Name of Physician

10. Name of Hospital

10. Name of Hospital

11. Name of Nurse

11. Name of Nurse

12. Name of Doctor

12. Name of Doctor

13. Name of Family

13. Name of Family

14. Name of Friends

14. Name of Friends

15. Name of Neighbors

15. Name of Neighbors

16. Name of Clergy

16. Name of Clergy

17. Name of Minister

17. Name of Minister

18. Name of Pastor

18. Name of Pastor

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00742

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park	
c. LENGTH OF STAY IN 1b 11 yrs.		d. STREET ADDRESS 1111	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Bruce Last Franz		4. DATE OF DEATH Month Jan. Day 31 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Whl. Flower's	
11. BIRTHPLACE (State or foreign country) Friendsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Frantz		14. MOTHER'S MAIDEN NAME Eliza Fike	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. - - - -	
17. INFORMANT Mrs. Loretta Crites		Address Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull 9035 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on ice in alley near home and struck head.	
20c. TIME OF INJURY Month, Day, Year 8:45 Hour a.m. 1-31 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Mt. Lake Park Garrett Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		22. DATE SIGNED 1-31-67 Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Garrett Co. Maryland	
24. FUNERAL DIRECTOR <i>Charles D. Minnich</i> ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE FEB 3 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

00785

00785

CERTIFICATE OF DEATH

Reg. Dist. No. **00743****00743**

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland				c. LENGTH OF STAY IN 1b 30 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Maggie D/ Hebb				4. DATE OF DEATH Month Day Year Jan 3 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1872		9. AGE (In years last birthday) 94 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Aurora, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel Lipscomb				14. MOTHER'S MAIDEN NAME Annie Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Raisy Hebb Rt 2 Oakland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Unknown				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29 1967 to Jan 3 1967 , that I last saw the deceased alive on Jan 2 1967 , and that death occurred at 3:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton		M.D. Oak 5th Sts, Oakland, Md.		ADDRESS (Street, city or town, state) Oak 5th Sts, Oakland, Md.		DATE SIGNED 5 Jan 67	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		OAK @ FIFTH Sts. Oakland, Md. 21550					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 5, 1967		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery		22d. LOCATION (City, town, or county) (State) Aurora, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Septor R. Hinkle Davis, 201/4				24a. REC'D BY REGISTRAR DATE JAN 9 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00748

CERTIFICATE OF DEATH

00748

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH St. Louis, Missouri		14. DATE OF DEATH April 4, 1968		15. TIME OF DEATH 2:01 PM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF NEXT OF KIN Mrs. James Earl Ray		18. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		19. SIGNATURE OF CLERK John Edgar Hoover		20. SIGNATURE OF WITNESS John Edgar Hoover	
21. SIGNATURE OF REGISTRAR John Edgar Hoover		22. SIGNATURE OF CLERK John Edgar Hoover		23. SIGNATURE OF WITNESS John Edgar Hoover		24. SIGNATURE OF DECEASED James Earl Ray		25. SIGNATURE OF NEXT OF KIN Mrs. James Earl Ray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00744											
1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Deer Park c. LENGTH OF STAY IN b. 64 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 2						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Deer Park d. STREET ADDRESS Rt. 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Etta Holtschneider						4. DATE OF DEATH January 27, 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/5/79		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Marietta, Ohio				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Deihl						14. MOTHER'S MAIDEN NAME Catherine McMahon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wilhelmina Browning Address Star Route Oakland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO MYOCARDIAL HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO ARTERIOSCLEROSIS										INTERVAL BETWEEN ONSET AND DEATH SUDDEN YRS. YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 20 YRS. 19... to 19..., that (I) (we) last saw the deceased alive on 1/27/67 19..., and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Andrew E. Mance M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/28/67			
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.						22d. ADDRESS OAKLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/67		23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION (City, town or county) Deer Park		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Munnich ADDRESS Oakland, Maryland						25a. REC'D BY REGISTRAR JAN 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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Blank certificate form with faint text and lines.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00745		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				00745				
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN lb 56 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland 11/1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cuppett-Weeks Nursing Home					d. STREET ADDRESS Rt. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Stephen Middle Elza Last Knotts					4. DATE OF DEATH Month January Day 26th Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/80		9. AGE (In years last birthday) yrs. 86		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) W. Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ezra Knotts					14. MOTHER'S MAIDEN NAME Sarah Fansler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Robert Sliger Address Cottage City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerosis, generalized DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>			EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			22. DATE SIGNED 1-26-67			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/66		23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Elk Garden W. Va.		24. FUNERAL DIRECTOR Gerald N. Minnich		
25a. REC'D BY REGISTRAR Oakland, Maryland				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE JAN 31 1967				

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James H. Fowler, Jr. • Editor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
00746														
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>					c. LENGTH OF STAY IN 1b <u>28 days, 21 hrs.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>					d. STREET ADDRESS <u>#3- S. 6th St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Norton</u> Last <u>Lohr</u>					4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1967</u>									
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/17/94</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>19</u> Mln. <u>67</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Bluffton, Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Norton, Charles Peter</u>					14. MOTHER'S MAIDEN NAME <u>Bell, Amanda Ellen</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>219-20-8258</u>					17. INFORMANT <u>Kermit Breunninger Lohr, Oakland, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hemiplegia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>915.</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>Apr</u> , 19 <u>64</u> , to <u>Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 Jan</u> 19 <u>67</u> , and that death occurred at <u>7:05M</u> from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE <u>B. L. Grant</u>					M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>14 Jan 67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. B. L. Grant</u>					22d. ADDRESS <u>Oakland, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>1/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beinhauer Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Pittsburgh, Pa.</u>						
24. FUNERAL DIRECTOR <u>John O. Durst</u> <u>Leighton-Durst Funeral Home, Oakland, Md.</u>					25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

00740

00740



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00747

CERTIFICATE OF DEATH

00747

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Garrett Co. Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McHenry, Maryland d. STREET ADDRESS Marsh Hill Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Everett Last Paugh		4. DATE OF DEATH Month Jan. Day 10 Year 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-98	
9. AGE (in years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Aircraft Elec.		10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
11. BIRTHPLACE (County & State, or foreign country) Maryland W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paugh, William Henry		14. MOTHER'S MAIDEN NAME Davis, Harvey Emma Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-7932	
17. INFORMANT (wife) Mary K. Paugh		Address McHenry, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Chronic Glomerulo-Nephritis DUE TO (b) Epistaxis DUE TO (c) Malignant Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gout		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. , 19 60 , to Jan. 10 , 19 67 , that (I) last saw the deceased alive on Jan. 10 , 19 67 , and that death occurred at 3:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. E.I. Baumgartner		22b. DATE SIGNED 1/11/67	
22c. PHYSICIAN'S NAME (Type) Dr. E.I. Baumgartner		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/67	
23c. NAME OF CEMETERY OR CREMATORY Garr Memorial Gardens		23d. LOCATION (City, town or county) (State) Oakland, Maryland	
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR JAN 16 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

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-d-

Handwritten signature

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00748		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				00748			
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Grantsville</u>			c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Grantsville</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <u>Charles George Reichenbecher</u>					4. DATE OF DEATH Month <u>Jan</u> Day <u>2</u> Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1885</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>(Rural) Grantsville Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Peter Reichenbecher</u>					14. MOTHER'S MAIDEN NAME <u>Ottillie Hanft</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Rosa Kamp, Grantsville, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>1-2-67</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Oakland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Luth. Com. Cove</u>		23d. LOCATION (City or Town) (County) (State) <u>Accident, Garrett Md.</u>			
24. FUNERAL DIRECTOR <u>Kurt E. Neumann</u>				ADDRESS <u>Grantsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>JAN 5 1967</u>					

84700

UNITED STATES DEPARTMENT OF AGRICULTURE

84700

UNITED STATES DEPARTMENT OF AGRICULTURE



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00749

CERTIFICATE OF DEATH

00749

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE, MO</u>	
c. LENGTH OF STAY IN 1b <u>3 YRS</u>		d. STREET ADDRESS <u>111</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>OAK REST NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN F. Savage</u>		4. DATE OF DEATH <u>Jan 11 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/86</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TIMBER CUTTER</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>FRIENDSVILLE, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. SAVAGE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA FRIEND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. MacDove, RONCO, PA</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Generalized</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>hemiplegia (right)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan</u> , 19 <u>67</u> , and that death occurred at <u>1 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>B.L. Grant M.D.</u>		22b. DATE SIGNED <u>12 Jan 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.L. Grant M.D.</u>		22d. ADDRESS <u>Oakland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SAND SPRING</u>		23d. LOCATION (City or Town) (County) (State) <u>FRIENDSVILLE MO GARRETT</u>	
24. FUNERAL DIRECTOR <u>Don Newman, Grantsville Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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2450

00750

CERTIFICATE OF DEATH

00750

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>00750/ Alexandria</u> <u>83.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cuppett-Weeks Nursing Home</u>				d. STREET ADDRESS <u>00750/ 1377 00750</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATE</u> Middle <u>E</u> Last <u>SHIRER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1881</u>	9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Philippi, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas E. Shirer</u>				14. MOTHER'S MAIDEN NAME <u>Mahala Spedden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-4754</u>		17. INFORMANT (Nephew) Address <u>Scott Shirer, Oakland, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA OF AGED</u> DUE TO (b) <u>ADVANCED ARTERIO SCLEROSIS</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> , 19 <u>67</u> , to <u>Jan. 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 21</u> , 19 <u>67</u> , and that death occurred at <u>10:35</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>E. I. Baumgartner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. I. Baumgartner, M.D.</u>				22d. ADDRESS <u>Oakland, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Oakland, Maryland</u>			
24. FUNERAL DIRECTOR <u>John O. Durst</u> <u>Leighton-Durst Funeral Home, Oakland, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00730

1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00751					00751									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Garrett MARYLAND					a. STATE Maryland b. COUNTY Garrett									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Gorman, W. Va.									
c. LENGTH OF STAY IN 1b 11 days					d. STREET ADDRESS Rt. 1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last Martha Alice SISLER					Month Day Year January 5 1967									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/24/93		9. AGE (In years last birthday) 73 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Red House, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME William Henry DEVERS					14. MOTHER'S MAIDEN NAME Sarah Ruhama HANLIN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-64-2862		17. INFORMANT Address (son) Julius Sisler, Gorman, W. Va.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>								3 days 5 yrs 1 year						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>5 Jan 1967</u> to <u>5 Jan 1967</u> , that (I) (we) last saw the deceased alive on <u>5 Jan 1967</u> , and that death occurred at <u>12:20</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Dr. Andrew E. Mance</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> P.M. STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6 Jan 67</u>							
22c. PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance					22d. ADDRESS Oakland, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/8/67		23c. NAME OF CEMETERY OR CREMATORY Volpe Family Cemetery		23d. LOCATION (City, town or county) (State) Near Oakland, Md.								
24. FUNERAL DIRECTOR John C. Durst Leighton-Durst Funeral Home, Oakland, Md.					25a. REC'D BY REGISTRAR DATE JAN 9 1967					25b. REGISTRAR'S SIGNATURE <u>John C. Durst</u>				

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #2		d. STREET ADDRESS Route #2	
3. NAME OF DECEASED (Type or print) First MAGDELENA Middle AGNES Last SLABACH		4. DATE OF DEATH Month January Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1877
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Md.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David J. Slabach		14. MOTHER'S MAIDEN NAME Catherine Schertz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Albert Sisk, Rt. #2, Oakland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-atherosclerotic Cardio Vasc. Disease DUE TO (c) 15 yrs.			INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY , 1952, to FEB 2 , 1967, that (I) (we) last saw the deceased alive on Jan 25 , 1967, and that death occurred at 2:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE E. I. Baumgartner		22b. DATE SIGNED 2/1/67	
22c. PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/2/67	23c. NAME OF CEMETERY OR CREMATORY Gortner Cemetery	23d. LOCATION (City or Town) (County) (State) Oakland, Maryland
24. FUNERAL DIRECTOR Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR John O. Durst	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 3 1967	

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FOR STATE HEALTH DEPT.

00753

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

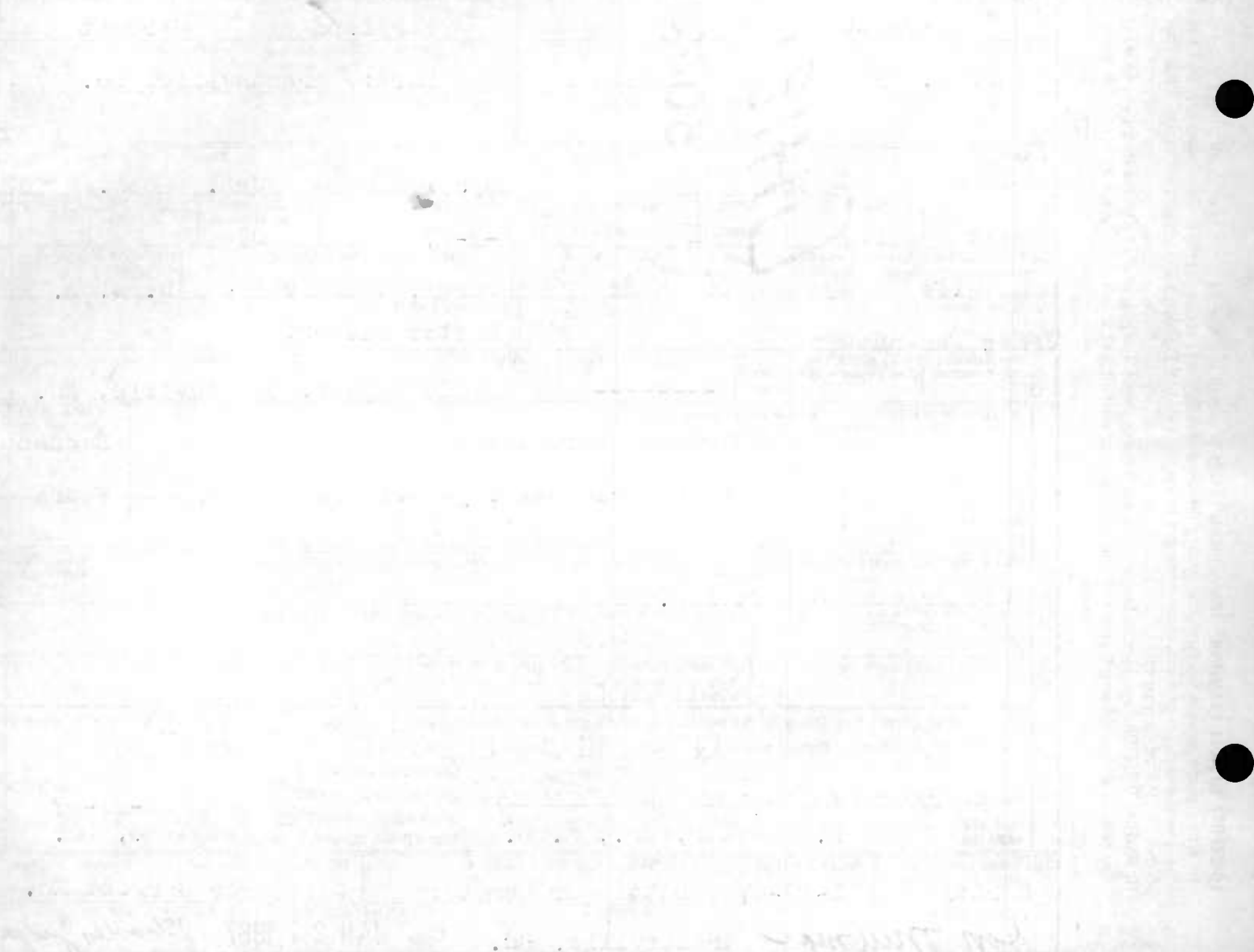
00753

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Grantsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Grantsville, Md. 11.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Ada Middle Snyder Last Snyder		4. DATE OF DEATH Month Jan. Day 20th. Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-77
9. AGE (In years last birthday) 89 yrs.		10. UNDER 1 YEAR Months 11 Days 1	11. UNDER 24 HRS. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Rural, Grantsville
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Fazenbaker	
14. MOTHER'S MAIDEN NAME Hester Siebert		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Winfield Snyder, Grantsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Arteriosclerosis, generalized DUE TO (c) Years			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old fractured left leg.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 1-21-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. ADDRESS San Trueman Grantsville, Md.		23b. REGISTRAR'S SIGNATURE Charles Judge	
23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-23-67	
23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
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23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
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23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-23-67	
23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
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23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
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23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
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23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger Garrett Md.	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00754					00754				
1. PLACE OF DEATH a. COUNTY <u>Garrett</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <u>2 Days 5 1/2 Hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bayard</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Garrett Co. Memorial Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <u>Timothy</u> Middle <u>Lynn</u> Last <u>Thorne</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 25, 1967</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>5</u> Days <u>2</u> Hours <u>52</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Oakland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RONALD LEE THORNE</u>					14. MOTHER'S MAIDEN NAME <u>SYLVIA KATHLEEN ZIRKLE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(MOTHER)</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7545</u> DUE TO <u>Pulmonary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (B.Wgt. 2 1/4 10g)</u> (c) <u>53 1/2 hrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>53 1/2 hrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 25, 1967</u> , to <u>Jan. 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 27 1967</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Herbert H. Leighton</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>27 Jan 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, MD.</u>					22d. ADDRESS <u>Oakland, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bayard Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bayard W. Va.</u>		
24a. FUNERAL DIRECTOR <u>Gerald N. Minnich</u>					ADDRESS <u>Oakland, Maryland</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 31 1967</u> <u>Charles Judge</u>		

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